

**Report to the Medical Board of California: Citation and Fine Program  
Failure to Comply with Required Disease Reporting**

❖ **Name of Person Filing Report:** \_\_\_\_\_

Title: \_\_\_\_\_

Jurisdiction: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

❖ **This is to notify the Medical Board of California that the physician named here has failed to comply with required disease reporting:**

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

❖ **Violation:** ☐ No Report ☐ Delayed ☐ Incomplete ☐ Refused on Request ☐ Other

Disease: \_\_\_\_\_ Reportable: ☐ Immediately ☐ Within 1 day ☐ Within 7 days

\_\_\_\_\_

\_\_\_\_\_

❖ **History of non-reporting and action(s) taken:**

Impact of non-reporting: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Actions to warn/educate: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Response by physician: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\* \* \* \* \*

Health Officer: \_\_\_\_\_  
(Signature)

Date: \_\_\_\_\_

Send to: **Medical Board of California, Enforcement Program, Central Complaint Unit, Attn: Dave Thornton,  
1426 Howe Avenue, Suite 93, Sacramento, CA 95825**